

PRINTED: 10/30/2017  
FORM APPROVED

## Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN4710</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>10/18/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>NHC HEALTHCARE, KNOXVILLE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>808 EAST EMERALD AVE KNOXVILLE, TN 37917</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  An annual Licensure survey and investigation of complaint #40329 was conducted from 10/16/17 through 10/18/17 at NHC Healthcare Knoxville. No health deficiencies were cited under Chapter 1200-8-8, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

0009

DDI-K11

If continuation sheet 1 of 1